Massachusetts Department of Public Health
PUBLIC HEALTH COUNCIL

Meeting of the Public Health Council, Tuesday, June 27, 2000, at 10:00 a.m., Massachusetts Department of Public Health, Public Health Council Room, Second Floor, 250 Washington Street, Boston, Massachusetts. Present were: Chairman Howard Koh, M.D., Dr. Clifford Askinazi, Mr. Manthala George, Jr., Thomas Sterne, M.D., Mr. Albert Sherman, Ms. Janet Slemenda and Ms. Shane Kearney-Masaschi. Mr. Benjamin Rubin absent. (One vacancy). Also in attendance was Donna Levin, General Counsel.

Chairman Koh announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance, in accordance with Massachusetts General Laws, Chapter 30A, Section 11A ½.

The following members of the staff appeared before the Council to discuss and advise on matters pertaining to their particular interests: Ms. Susan Etkind, R.N., M.S., Director, Division of Tuberculosis Prevention and Control; Dr. Edward Nardell, M.D., Tuberculosis Control Officer; Ms. Joyce James, Director and Ms. Holly Phelps, Consulting Analyst, Determination of Need Program; and Attorney Carl Rosenfield, Deputy General Counsel, Office of the General Counsel.

PERSONNEL ACTIONS:

In a letter dated June 9, 2000, Katherine Domoto, M.D., MBA, Associate Executive Director for Medicine, Tewksbury Hospital, recommended approval of the appointments and reappointments to the provisional affiliate, consultant and allied medical staff of Tewksbury Hospital, Tewksbury. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Associate Executive Director for Medicine of Tewksbury Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following appointments and reappointments to the medical staff of Tewksbury Hospital be approved for a period of two years beginning June 1, 2000 to June 1, 2002:

APPOINTMENTS:	**STATUS/SPECIALTY:**	**MED. LICENSE NO.:**
Kelly Clark, MD	Provisional Affiliate/Psychiatry	81665
Stephen Ellen, MD	Provisional Affiliate/Psychiatry	73606
Mimi Tehein, MD	Provisional Affiliate/Psychiatry	153783

REAPPOINTMENTS:	**STATUS/SPECIALITY:**	**MED. LICENSE NO.:**

Daniel Berman, MD	Consultant Radiology	73877
Dan Seligman, DPM	Consultant Podiatry	1598
Susan Rudman Carnevale, EdD	Allied Psychology	6593
Alexandria Weida, EdD	Allied Psychology	6594

In a letter dated June 13, 2000, Mr. Blake Molleur, Executive Director, Western Massachusetts Hospital, Westfield, recommended approval of the reappointments to the active and consultant medical staff of Western Massachusetts Hospital. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Western Massachusetts Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments be approved as follows:

REAPPOINTMENTS:	**RESPONSIBILITY:**	**MED. LICENSE NO.:**
Chabilal Neergheen, M.D. (Active)	Internal Medicine	40509
Gary Kaskey, M.D. (consulting)	Psychiatry	47764

In a letter dated June 12, 2000, Mr. Robert D. Wakefield, Jr., Executive Director, Lemuel Shattuck Hospital, recommended approval of the reappointments to the medical staff of Lemuel Shattuck Hospital, Jamaica Plain. Supporting documentation of the appointees' qualifications accompanied the recommendation. After consideration of the appointees' qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Executive Director of Lemuel Shattuck Hospital, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the following reappointments to the medical staff of Lemuel Shattuck Hospital be approved:

REAPPOINTMENTS:	**RESPONSIBILITY:**	**MED. LICENSE NO.:**
Floyd Atkins, M.D. (active)	Cardiology	53806
Joseph Cohen, MD (active)	Oncology	27226
Stephen Drewniak, MD (active)	Gastroenterology	43997
David Haskell, MD	Psychiatry	29473

(active)		
Robert Tarpy, MD (active)	Pulmonary	72824
Maria Warth, MD (consultant)	Endocrinology	53898

In a memorandum dated June 14, 2000, Dr. Howard Koh, Commissioner, Department of Public Health, recommended approval of the appointment of Cynthia Deane Mahr to Administrator V (Director, Administration and Finance). Supporting documentation of the appointee's qualifications accompanied the recommendation. After consideration of the appointee's qualifications, upon motion made and duly seconded, it was voted (unanimously): That, in accordance with the recommendation of the Commissioner of Public Health, under the authority of the Massachusetts General Laws, Chapter 17, Section 6, the appointment of Cynthia Deane Mahr to Administrator V (Director, Administration and Finance) be approved.

"1999 TUBERCULOSIS STATISTICAL REPORT" - BY SUSAN ETKIND, R.N., M.S., DIRECTOR, DIVISION OF TUBERCULOSIS PREVENTION AND CONTROL AND DR. EDWARD NARDELL, M.D., TUBERCULOSIS CONTROL OFFICER:

Ms. Susan Etkind, R.N., M.S., Director, Division of Tuberculosis Prevention and Control, said in part, "We are here to present the 1999 data on tuberculosis and the status of turberculosis control efforts in Massachusetts…In 1999, Massachusetts continued to maintain a low TB case rate of 4.49 per 100,000…Our rate represents a 5 percent decrease from 1998, and a 37 percent decline since 1992. In terms of basic demographics, sixty percent of the cases were reported from two counties; Middlesex and Suffolk. Suffolk county continues to account for approximately one-third of all the TB cases reported; and Middlesex County for an additional twenty-five percent. Fourteen communities account for sixty-seven percent of the cases. The city of Chelsea continues to have the highest case rate of 24.38 per 100,000. Boston experienced a fifteen percent decline in reported cases in 1999, and that was the lowest rate ever reported for the city. Places reporting increase included Brockton and Lawrence, Framingham, Lowell, Lynn and Worcester…In addition to Boston, other cities reporting decreases in case rates included Cambridge, Quincy, Somerville, and Springfield. Fifty-five percent of our cases in 1999 were male. Case rates indicate a greater decline in male TB cases. Cases in the 25 to 44 year old age group continued to represent the largest proportion of cases; thirty-eight percent. Nineteen percent of our cases were age 65 or older, a continuing decline. Only twenty-eight percent of the TB cases in 1999 were white, non-Hispanic. Seventy-two percent were among persons of color. Case rates for Asian /Pacific Islanders have increased from 43.2 per hundred thousand in 1988 to 60 in 1999. For blacks, the case rate has declined from 48.1 percent in 1991 to 27.0 in 1999. Although we have achieved TB elimination among

white, non-Hispanic persons in Massachusetts, this is clearly not the case for other groups."

Ms. Etkind continued, "In terms of children, although case rates in children and teens remain very low, 3.3 per 100,000 in 1999, seventy-seven percent of those were reported among persons of color. In terms of drug resistance, in 1999, 9.7 percent of all of our bacteriologically confirmed TB cases had some form of drug resistance. This is slightly less than previous years…Almost fourteen percent of the drug resistant cases were among white, non-Hispanics, and the balance of all drug resistant cases were born outside of the United States. This is Haiti, Vietnam, China, Cape Verde, and other. On the national level, four factors have been suggested to account for the early rise in TB. The first of these is the increased immigration….TB in the developing world continues to be a staggering problem. It is the leading infectious killer of adults worldwide. It is responsible for twenty-five percent of avoidable death in the developing world. Nearly one million reproductive age women die every year of tuberculosis. It is the leading case of HIV-associated mortality in the world. There were almost eight million TB cases reported in 1997. Over three million cases, or forty-two percent of the total were reported from 173 countries…In 1996, only fifty-four percent of the cases that were detected were successfully treated. That's only twenty-three percent of the total. This is TB in the world today. The number of cases in some areas of the world are in the millions. So much of Africa and parts of South America are heavily impacted.
Although TB cases continue to decline in parts of Western Europe and Latin America, they are rising in Eastern Europe, Africa, and Asia….Rates in some parts of Africa exceed 999 per 100,000. It is extremely difficult to collect data from these high morbidity areas... TB is increasing, and it is due to an increase in HIV and lack of effective TB control programs. And MDR TB is on the rise. However, TB, in spite of all this, is a treatable, curable, and preventable condition. Global attention needs to be focused on this ever-worsening problem. But it is a problem that is not without hope. .."

Ms. Etkind continued, "When you look at our cases by geographic region, the majority were from Asia, followed by the the Caribbean, and Africa. Sixty-eight percent of these cases were from ten countries, including Vietnam, Haiti, China, India, Cambodia, Dominican Republic, Portugal, Cape Verde, Brazil and Somalia. In 1999, fifty-three different countries of the world were represented. An analysis of age groups indicates that the foreign-born tend to be younger than those born in the U.S. The next high risk group in Massachusetts is the homeless. In 1999, we only had 12 cases reported among this group. Case rates in this population are estimated at somewhere around 52 per 100,000, and equally distributed between Boston, and non-Boston cases. Moving on to corrections, we continue to have very few cases reported from this setting. In 1999, less than one percent of the cases we had in Massachusetts came from correctional facilities. Only 4 percent of the cases were reported from long term care facilities. The third factor associated with the earlier rise in TB was the HIV

epidemic. There have been 547 TB/AIDS cases identified. In 1999, 10.7 percent of our reported cases were co-infected with HIV. Persons of color account for the majority of TB/AIDS cases. Forty percent of the TB/AIDS cases were born outside of the U.S. and the majority of those were in Haiti…" In conclusion Ms. Etkind said, "There are clear indicators that we are continuing to make substantial progress toward our goal of TB elimination in Massachusetts…As we move toward elimination, efforts to address the burden of disease for those persons who have latent TB infection who are not yet represented by this data will need to be strengthened and supported…"

Dr. Edward Nardell, M.D., Tuberculosis Control Officer, said in part, "It is a pleasure to discuss tuberculosis in Massachusetts with you and talk about tuberculosis elimination. We are heading in a downward trend, which is great. Tuberculosis elimination, particularly as it is being redefined at a lower rate than one case in a million, will take a very long time at the current rate of decline. Part of the problem is that these 270 active TB cases that we discuss are just a tip of a larger iceberg of infection that is really the source of these cases. One can estimate that somewhere between 300,000 and 600,000 persons have latent TB in Massachusetts. The way to prevent this latent TB infection from becoming active is through this process of targeted testing and treatment that the CDC and the American Thoracic Society report addresses…The current situation of declining cases, multiple active cases, infect other people in the population, contributing to this pool of latent infection from which other cases come. This is the situation in Massachusetts with more cases producing infection, but then ultimately fewer cases resulting from that, due to the natural history of the disease. There are several steps one can take in TB prevention and control. One of them, is to treat the active cases. We think we are doing a good job of that. We are detecting most of the cases early on, treating them completely. And in that way, also interrupting them completely. In addition, there are infection control measures that have been taken in recent years to cut down on transmission. Immunization has not had a big role in this country. There are hopes for a new vaccine for global use, but at the moment there is no new vaccine. Some of these vaccines may actually be targeted for people who are already infected. Here we have this large pool of latent infection that is going to be a source of cases. We know how to detect that and we have treatments to interrupt that latent infection so this does not happen."

" The Institute of Medicine report has five points. One is to maintain control; to adapt our programs to declining incidence, which we are doing; to adapt to a changing health care structure, which we are addressing, and managed health care, for example. The second point was to speed decline toward elimination through targeted testing and treatment of latent infection. This is something that was always done, but we have never made it a major focus because we have been focusing on active disease. They encouraged the development of new tools, treatments, and vaccines...and, they encourage mobilizing support for elimination, and measuring progress towards that goal. And that is in part what

we are about here today. The risk groups for Massachusetts are the foreign-born, particularly recent arrivals, low-income persons, especially the homeless, and the elderly…"

Dr. Nardell continued, "…Several years ago, we made the case that most school and other mandatory testing in Massachusetts is not warranted, anywhere in the United States. We are still doing that in Massachusetts…we encourage school testing not to happen on a schoolwide basis, but based on individual risk factors…The rationale for treating latent infection is that the risk of TB is lifelong if you carry the infection, and about 5 to 10 percent of such people go on to develop the disease. Much of this risk is in the first couple of years after infection. The risk of treatment is low, especially with the new two month treatment that we have available…We try to kill these dormant TB germs, and thereby reduce by more than 90 percent a chance of reactivation. This obviously has a tremendous personal health benefit, but also a public health benefit, and is considered critical for TB elimination in the United States and also in Massachusetts. Some new treatment options are highlighted in the recent Center for Disease Control and American Thoracic Society report. The new guidelines are emphasizing longer treatment than the one physicians have preferred for many years. They also offered a new combination of old drugs…So, we have some new tools. We have a mandate, and we are ready to make some inroads in terms of TB elimination in Massachusetts."

DETERMINATION OF NEED PROGRAM:

CATEGORY 2 APPLICATION:

PROJECT APPLICATION NO. 4-1422 OF BEVERLY ENTERPRISES-MASSACHUSETTS, INC. – RENOVATION OF THE 97-BED WELLESLEY MANOR NURSING HOME:

Ms. Holly Phelps, Consulting Analyst, Determination of Need Program said, "Beverly Enterprises of Massachusetts is proposing to renovate the 97-bed Wellesley Manor Nursing Home, and also to delicense 25 of its beds. The original proposal was to have included new construction, but following discussions with staff, the revised proposal just includes renovation and the delicensing of 25 beds, so that the final bed complement will be 72 beds. Staff finds that the revised proposal meets all the factors in the nursing home renovation and replacement guidelines, and we recommend approval with the conditions in the staff summary. There was a Ten Taxpayer Group formed, the George Psyhogeos Ten Taxpayer Group, composed of owners of property abutting the Wellesley Nursing Home. Most of the concerns they raised were really beyond the purview of DON review, such as the location of the access road. They were concerned about the security of the building before construction began; and also the perogatives of the licensing by the owner to turn the facility into another kind of facility on the same site at some point in the future. The Ten

Taxpayer Group did not comment on the staff summary recommending approval of the project. They formed at a time when the project included the new construction, but they were satisfied with the project now that they know it is only going to be renovation. In terms of the concerns that they had that were not related to DoN issues, the applicant had met with the Ten Taxpayer Group before the hearing. There is a good relationship there. Staff is continuing to recommend approval of the project, with conditions in the staff summary."

After consideration, upon motion made and duly seconded, it was voted unanimously **to approve Project Application No. 4-1422 of Beverly Enterprises – Massachusetts, Inc.,** based on staff findings, with a maximum capital expenditure of $3,461,232 (January 2000 dollars) and first year incremental operating costs of $538,457 (January 2000 dollars). A summary is attached to and made a part of this record as **Exhibit Number 14,678**. As approved, the application provides for renovation of the 97-bed Wellesley Manor Nursing Home. This Determination of Need is subject to the following conditions:

1. The Applicant shall accept the approved maximum capital expenditure of $3,461,232 (January 2000 dollars) as the final costs figure except for those increases allowed pursuant to 105 CMR 100.751 and 752.

2. The Applicant shall, prior to construction, sign a formal affiliation agreement with at least one local acute care hospital and one local home care corporation that addresses provision for respite services.

3. The Applicant shall delicense 25 Level II beds.

4. The Applicant shall guarantee beds in the renovated facility for residents residing in Wellesley Manor Nursing Home at the time of submission of the DON.

5. The Applicant shall ensure that Medicaid transfers from the older facility to the new facility will continue to receive care until such time that Medicaid certification is obtained.

6. The Applicant shall obtain Medicare certification for its proposed Level II beds.

7. The approved gross square feet (GSF) for this project shall be 33,281 GSF for renovation of the existing facility.

8. The approval is conditional upon the Executive Office of Environmental Affair's (EOEA) final determination on the appropriateness of the proposed site. The Applicant shall notify the Department of EOEA's determination of whether an environmental impact report for the site is required.

9. Upon implementation of the project, any assets such as land, building improvements, or equipment which are either destroyed or no longer used for patient care, shall not be claimed for reimbursement for publicly aided patients.

10. The Department shall reserve the right to conduct a review of the financial feasibility of the project based on the Division of Health Care Finance and Policy's established rates of reimbursement for Medicaid patients at the time final maximum capital expenditures or any adjustments to the final maximum capital expenditures are submitted to the Determination of Need Program for approval in the event that such expenditures exceed the approved maximum capital expenditure. The Applicant shall submit a revised Factor Five (Financial Schedules) upon request by the Department. The Applicant is advised that an increase in equity may be necessary to assure the financial feasibility of the project.

The meeting adjourned at 11:05 a.m.

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Howard K. Koh, M.D., M.P.H
Chairman

LMH/sb